

Premier Plan Coverage

OPTION: 0% Coinsurance

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

PLAN LIFETIME MAXIMUM

OPTION: 20% Coinsurance

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

CALENDAR YEAR DEDUCTIBLE
CALENDAR YEAR OUT-OF-POCKET LIMIT (includes deductible)

PLAN LIFETIME MAXIMUM

Premier Plan Benefits¹

DOCTORS' OFFICE VISITS

PREVENTIVE CARE (includes well-child care, preventive office exams, immunizations, PSA screening, Pap smears, mammograms, colorectal cancer exams, colonoscopy, and sigmoidoscopy)

DIAGNOSTIC SERVICES

HOSPITAL (inpatient & outpatient), **OUTPATIENT SURGERY**

EMERGENCY ROOM SERVICES

VISION

MATERNITY

DENTAL

LIFE

Premier Plan Drug Coverage

PREMIER INCLUDES COMPREHENSIVE DRUG COVERAGE

PURCHASE OF TIER 1 DRUGS (generic required if available)

PURCHASE OF BRAND AND/OR SPECIALTY DRUGS (tiers 2, 3, and 4)

In network subject to a separate deductible and out-of-pocket limit.
 Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.

PREMIER DRUG OPTIONAL UPGRADE (\$15 / \$30 / \$60 / 25% Plan)

Note: Tier 4 drugs are subject to a separate \$2500 prescription drug out-of-pocket limit which is combined for retail and mail.

RETAIL PHARMACY:

SPECIALTY DRUGS:

MAIL SERVICE:

OTHER COVERED BENEFITS INCLUDE BUT ARE NOT LIMITED TO:

- Ambulance
- Chiropractic
- Durable Medical Equipment
- Home Health Care
- Hospice Care
- Mental Health
- Organ Transplants
- Rehabilitation Facilities
- Skilled Nursing Care
- Speech Therapy
- Therapy Services
- Urgent Care

Network				
YOU PAY 0% Coinsurance				
Individual:	\$2,500	\$3,500	\$5,000	\$10,000
	\$2,500	\$3,500	\$5,000	\$10,000
Family:	\$5,000	\$7,000	\$10,000	\$20,000
	\$5,000	\$7,000	\$10,000	\$20,000
\$7,000,000 per member for network and non-network services combined				

YOU PAY 20% Coinsurance					
Individual:	\$250	\$500	\$1,000	\$1,500	\$2,500
	\$2,750	\$3,000	\$3,500	\$4,000	\$5,000
Family:	\$500	\$1,000	\$2,000	\$3,000	\$5,000
	\$5,500	\$6,000	\$7,000	\$8,000	\$10,000
\$7,000,000 per member for network and non-network services combined					

Non-Network				
YOU PAY 40% Coinsurance				
Individual:	\$2,500	\$3,500	\$5,000	\$10,000
	\$10,000	\$11,000	\$12,500	\$17,500
Family:	\$5,000	\$7,000	\$10,000	\$20,000
	\$20,000	\$22,000	\$25,000	\$35,000
\$7,000,000 per member for network and non-network services combined				

Network:	
YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED	
OFFICE VISIT COPAY: \$30 copay for primary care physician (deductible waived); \$40 copay for specialist (deductible waived)	
OTHER SERVICES: 0% or 20% Coinsurance ²	
PREVENTIVE OFFICE VISIT COPAY: \$30 copay for primary care physician (deductible waived); \$40 copay for specialist (deductible waived)	
PREVENTIVE CARE SERVICES: 20% Coinsurance (deductible waived)	
0% or 20% Coinsurance ²	
\$20 Copay	
Not covered (optional maternity rider available for plans with \$2,500 individual/\$5,000 family or greater deductible; subject to 270-day waiting period)	
Coverage available at additional cost	

Non-Network	
YOU PAY YOUR SHARE AFTER DEDUCTIBLE, UNLESS WAIVED	
40% Coinsurance	
0% or 20% Coinsurance ²	
Cost of exam: All charges except \$35 (deductible waived)	
Not covered	
Coverage available at additional cost	

Network				
YOU PAY				
30 day supply: \$15 copay; 90 day mail order supply: \$30 copay				
Separate \$250 per person deductible for Brand & Specialty drugs.				
Greater of \$30 copay or 40% coinsurance up to \$4,000 max out-of-pocket. Member is responsible for difference in allowable charge between brand and generic, plus the copayment or coinsurance.				

Non-Network				
YOU PAY				
50% Coinsurance (minimum \$60) per prescription				
Note: Specialty injectable drugs only available through Anthem's Specialty Rx network and are not covered out-of-network.				

YOU PAY PER PRESCRIPTION				
Services with copays are not subject to deductible For detailed explanation of drug tiers, see inside.				
	TIER 1:	TIER 2:	TIER 3:	TIER 4:
(30-day supply)	\$15	\$30	\$60	25%
(30-day supply only)	\$15	\$30	\$60	25%
(90-day supply)	\$30	\$75	\$150	25%

YOU PAY PER PRESCRIPTION				
For detailed explanation of drug tiers, see inside.				
	TIER 1:	TIER 2:	TIER 3:	TIER 4:
(30-day supply)	50% (minimum \$60) per prescription order			
(30-day supply only)	Not covered			
(90-day supply)	Not covered			

¹UNLESS OTHERWISE NOTED, ALL BENEFITS ARE SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.

²COINSURANCE IS DESIGNATED BY THE PLAN YOU CHOOSE.

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Premier Benefit Guide, the terms of the contract or certificate of coverage will prevail.

Understanding Premier Coverage

Is your doctor or dentist in
one of our networks?

[Go to anthem.com](https://www.anthem.com) > [Find a Doctor](#)

Explanation of Benefits

Deductible: The amount of out-of-pocket expenses you have to pay each year before your health plan kicks in and starts paying for services. Network and non-network deductibles are separate and do not accumulate towards each other.

Coinsurance: The percentage of money you have to pay out of your own pocket for covered services. It's the portion of the bill not paid by your health plan after your deductible has been reached.

Copay (copayment): A specific dollar amount you have to pay out of your own pocket for covered services.

Out-of-pocket limit: The total amount of money (not counting your premiums) you have to pay each year for your health care coverage. Your deductible and coinsurance payments for covered services count toward your out-of-pocket limit. Network and non-network out-of-pocket limits are separate and do not accumulate towards each other.

Premium: The amount of money you pay on a regular basis — once a month, four times a year, twice a year or once a year — to your insurance company to keep your health plan active. You can't apply what you pay for your premium toward your deductible.

Covered service: This refers to the health care services that are covered by your health plan.

Brand-name drugs: Drugs that are manufactured and marketed under a registered trade name.

Generic drugs: Have the same active ingredients as their brand-name equivalent and provide the same clinical benefits.

Specialty drugs: High cost, scientifically engineered drugs that are usually injected or infused.

Save with tiered pricing

The cost of prescription drugs can be staggering. In fact, prescription drug costs are one of the leading drivers of rising health care costs. Helping control those costs is key to providing affordable health care and health insurance to everyone.

Generic Drugs

You get the best value when you choose generic drugs when available. The cost-sharing design for each plan is different, to help you find a prescription drug benefit that best fits your needs and budget.

Tiered Drugs

Your Benefit Guide chart shows tiered pricing for the Prescription Drug Upgrade Option. Within the brand, generic and specialty drug categories, drugs are sometimes assigned a cost “tier”.

The following explains the four cost tiers:

- **Tier 1 drugs:** Includes mostly preferred generic prescription drugs, but also include some lower cost brand-name drugs considered to have the greatest therapeutic value.
- **Tier 2 drugs:** Includes preferred brand-name and/or generic drugs that are lower-cost and provide greater therapeutic value than comparable brand-name drugs.
- **Tier 3 drugs:** Includes mostly brand-name drugs that cost more or are less efficient than comparable drugs on lower tiers, but Tier 3 may also include some high-cost generic drugs.
- **Tier 4 drugs:** Generally includes self-injectable drugs. The list of Tier 4 drugs can be found at anthem.com or by calling the number on the back of your ID card.

About our network providers

Notice of provider arrangements

Your network provider's agreement for providing covered services may include financial incentives or risk-sharing relationships based on utilization and quality of services. If you have any questions, please contact Anthem or your provider.

To help you avoid unnecessary out-of-pocket expenses

For some services or supplies (such as prescription drugs), your doctor must receive authorization from Anthem that defines and/or limits the conditions under which the service or supply will be covered. For other services (such as organ transplants), your doctor must certify (and Anthem must approve) that the service is medically necessary and takes place in the appropriate setting. Neither process is a guarantee of coverage.

Using non-network providers

If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed for covered services and the maximum allowable amount your plan covers plus any deductible, copayments, coinsurance and charges that are not covered.

For more complete coverage

Dental and Term Life Insurance

You can combine this health plan with Dental Blue® and/or Blue Preferred® Term Life Insurance. Combining coverage is not only easy, it can save you money, too. And you'll only have to deal with one application, one bill and one monthly premium.

Anthem

Premier

Benefit Guide for Ohio

Who can apply?

You can apply for Premier coverage for yourself or with your family. You must be a resident of the state in which you are applying, under the age of 65, a legal resident of the U.S. and not currently pregnant. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn 25.

What's a preexisting condition?

Generally, Premier covers preexisting conditions after you've been enrolled in the plan for 12 months. A preexisting condition is any medical or physical condition you had in the six months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition – or if it was recommended that you do so – that qualifies it as “preexisting”.

If you apply for coverage within 63 days of terminating your membership with another “creditable” health care plan, then you can use your prior coverage for credit toward the 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

What we do not cover.

Premier plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see “What's a preexisting condition?”); private duty nursing; maternity services, unless optional maternity rider is purchased; experimental or investigative treatment; dental, except as spelled out in your contract; charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; treatment that's primarily intended to improve your appearance; weight loss programs or treatment of obesity; hearing aids; eyeglasses or contact lenses; radial keratotomy or keratomileusis or excimer laser photo; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; TMJ and Craniomandibular Joint Disorders and services we determine aren't medically necessary.

These are just some of Premier plans' limitations and exclusions. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

Our appeal rights and confidentiality policy.

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal.

If you are denied coverage based on medical necessity or experimental/ investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal.

Please call customer service or check your certificate of coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to: **Anthem Blue Cross and Blue Shield, Appeals Coordinator, P.O. Box 33200, Louisville, Kentucky 40232-3200**

If we uphold our decision throughout the appeals process, you can request a review by the Ohio Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Ohio. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

We want you to be satisfied.

If you aren't satisfied with your Premier coverage, you can cancel it within 30 days after you receive your contract or certificate of coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your contract or certificate of coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

This brochure is only a summary of Premier benefits and is not a part of the contract or certificate of coverage. If you are approved for coverage, the contract or certificate of coverage you receive will include all the details of your plan. In the event of a conflict between the information in this brochure and your contract or certificate of coverage, the terms of your contract or certificate of coverage will prevail. Read your contract or certificate of coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the contract or certificate of coverage.

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INDIVIDUAL HEALTH PLANS

Anthem 



Introducing Premier for individuals.

The family-friendly,
benefit-packed,
good-for-your-health
health plans.

Premier health plans:

The solid coverage you need to keep your family healthy.

Why it's important to have health coverage

Whether you're self-employed, an early retiree, a recent graduate or don't have health coverage at work, an Individual health plan could be just what the doctor ordered. Why?

You never know. Even if you are healthy right now, an unexpected illness or injury could be right around the corner.

You work hard for your money. These days, a single day in the hospital can cost thousands of dollars. Without health coverage, you're taking a huge financial risk.

So why take chances? Our Individual health plans make it easier than ever to get the health coverage you need at a price you can afford. And no matter where you are in life...there's an Individual plan that will fit your health care needs, as well as your budget.

As you read this brochure...

Here are some explanations of terms to help you better understand how Premier plans work and the coverage they offer:

- **Deductible:** The amount of money you have to pay each year before the plan starts paying benefits. Generally, the higher a plan's deductible is, the lower the monthly premium.
- **Coinsurance:** After your annual deductible is met, your health plan will start to pay a portion of your covered medical expenses. Your share of the cost is your coinsurance.
- **Copay (copayment):** A specific dollar amount you have to pay out of your own pocket for covered services.
- **Premium:** The amount you must pay to maintain your health plan coverage. (Your premiums do not count toward your annual deductible.)
- **Covered medical expense:** This refers to the health care services that are covered by your health plan.
- **Brand-name drugs:** Drugs that are manufactured and marketed under a registered trade name.
- **Generic drugs:** Have the same active ingredients as their brand-name equivalent and provide the same clinical benefits.
- **Specialty drugs:** High cost, scientifically engineered drugs that are usually injected or infused.

Any questions?

Just call your Anthem Blue Cross and Blue Shield agent.

Why Premier health plans are a smart choice

If you have young children, or plan to have a family, Premier health plans were designed with your needs in mind. Packed with benefits, Premier focuses on the preventive care services your family needs to stay healthy and grow strong. And, a wide range of pricing options and coverage choices help you choose a plan that's affordable.

How Premier plans work

Because Premier plans are PPO (preferred provider organization) health plans, each plan:

- **Has an annual deductible.** This is the amount you have to pay out of pocket each year before your plan starts paying.
- **Starts paying a portion of your covered medical expenses** once your annual deductible is met. Your share of costs for covered services is called your coinsurance.
- **Saves you more money when you use a doctor in the PPO network.** For a list of network doctors, go to anthem.com, access your state's home page and click on "Find a Doctor."

Premier-at-a-glance

Plan overview:

- Lots of benefits with a focus on preventive care
- Coverage and pricing options let you choose your plan
- Ideal for families who have young children

Offers:

- A choice of annual deductible/ monthly premium combinations
- Easy copays for doctor visits
- Annual vision exam*
- Optional maternity benefit rider available

Rx coverage:

- No deductible for generic drugs
- Separate deductible for brand-name and specialty
- Optional drug upgrade available for additional prescription benefits

Good to know:

- Members receive the highest level of benefits by visiting a Network provider (See page 5)
- You can add dental and term life benefits to your health plan (See page 4)

* No annual vision exam available in the Wisconsin POS network

Built-in prescription drug coverage

The high cost of today's prescription drugs can be a financial drain on young families. That's why every Premier plan helps pay for:

Generic drugs: Coverage is immediate with no deductible to worry about. You'll always save the most when you choose generic drugs.

Brand-name and specialty drugs: Each member on your plan will have to pay a separate annual deductible before coverage starts. If you choose a brand-name drug when generic is available, Premier will pay the allowed amount for the generic drug and you'll have to pay the difference.

Good to know: Premier also has an optional drug upgrade available, which includes more prescription drug benefits for an additional premium each month. See your Premier Benefit Guide for details.

How Premier gives you the Anthem advantage

Experience you can rely on

Anthem Blue Cross and Blue Shield has been providing health coverage to families like yours for decades. Our experience has taught us how to create health plans that deliver the quality benefits and plan features our members want and need most, including:

- **Large provider networks with more choices of doctors and hospitals.** This increases the chances that your favorite doctors are on your plan's network.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And providers in our network across the country help make it easy to get the care you need.
- **No referrals or paperwork.** You won't need a referral to see a specialist. And there are no claims or paperwork when you use one of our network providers.
- **MyAnthemSM.** Register at anthem.com so you can review your benefits; check the status of claims and much more – right from your computer.

Highest Level of Benefits available with In-Network Providers

Anthem Blue Cross and Blue Shield has negotiated with our network doctors, hospitals and other health care providers to help you save on their services. In fact, you'll save in two ways:

- 1. Before your deductible is met:** During this time you'll be paying your medical expenses out-of-pocket. You benefit from lower negotiated fees when you choose a provider from the network.
- 2. After your deductible is met:** Even though your Premier plan will start paying a portion of your covered expenses, your share will be less when you choose a network provider.

Optional Term Life Insurance

For just pennies a day, you can add Anthem Blue Preferred[®] Term Life Insurance to your Premier health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your Premier PPO application to apply for coverage.

Support from Anthem

At Anthem, one of our goals is to improve the health of our members. That's why we give you access to a group of online tools and programs designed to help you take charge of your health.

Whether you're already healthy...or trying to improve your current physical condition, Anthem offers programs like these to support your efforts:

- Online articles, tools and videos to help manage and maintain your health
- Future Moms[®] program* where expectant parents can receive support for healthy pregnancy and delivery by dedicated trained obstetrical nurses.
- Learn your overall health status by completing the MyHealth Assessment.

For more information, go to anthem.com

*FutureMoms is an added service and is not covered maternity benefits. Optional maternity benefits are available for an additional cost.

Combining coverage is easy.

One application, one bill and one monthly payment does it all!

Term Life Monthly Rates

Age	\$15,000	\$25,000	\$50,000
1-18	\$1.50	\$2.50	N/A
19-29	\$2.85	\$4.75	\$9.50
30-39	\$3.30	\$5.50	\$11.00
40-49	\$7.50	\$12.50	\$25.00
50-59	\$20.85	\$34.75	\$69.50
60-64	\$29.40	\$49.00	\$98.00

How to add dental coverage to your Premier health plan

Dental Blue® plans

Regular dental check-ups and cleanings are important to your overall health. That's why we give you the option of adding one of these Dental Blue plans to your Premier health coverage:

- 1. Dental Blue Basic 100:** Gives you coverage for the basics, like routine check-ups and fillings. If your dental needs are simple, this may be the right plan for you.
- 2. Dental Blue Essential 200:** Includes coverage for the basics, plus services like crowns, bridges, root canals and dentures. If you think you may need major dental work, this is the right plan for you. This also plan gives you a wider choice of network dentists in exchange for a slightly higher cost. If your favorite dentist is in our larger network, this plan may be the best choice for you.

How dental networks help you save

While both Dental Blue plans allow you to go to any dentist, you'll save the most money when you choose a dentist from your plan's network. There are two Dental Blue networks:

- **Dental Blue 100 network:** This is the value network for our Dental Blue 100 plans. Dental Blue Basic 100 members can save the most on dental care when they choose a dentist from this network.
- **Dental Blue 200 network:** Includes the entire 100 network plus even more choices of dentists and specialists. Dental Blue Essential 200 members can save the most on dental care when they choose a dentist from this network.

How to choose the dental plan that works best for you

Use the chart below to compare dental plan benefits side by side.

Plan Names	Dental Blue Basic 100	Dental Blue Essential 200	All Plans*
Networks	Dental Blue 100	Dental Blue 200 (which includes all Dental Blue 100 dentists)	Benefit from negotiated rates at Dental Blue providers.
Preventive and diagnostic care	100% covered within plan network Includes routine checkups, x-rays and fluoride applications for children.	100% covered within plan network Includes Basic 100 services plus space maintainers.	No waiting period; no deductible in or out-of-network; covers two routine cleanings and oral exams per year; molar/bicuspid x-rays; full mouth x-rays covered once every five years
Minor restorative dental care	80% covered within plan network after \$50 deductible* Includes fillings and space maintainers. Extractions not covered.	Pays set amount within plan network and out-of-network after \$50 deductible* Includes fillings and extractions. Space maintainers are considered preventive/diagnostic care.	No waiting period
Major restorative dental care	Not covered	Pays set amount within plan network and out-of-network after \$50 deductible* Includes crowns, bridges, root canals and dentures.	12-month waiting period with Dental Blue Essential plan options

* Per member, per calendar year

All plans include discounts on non-covered services like teeth whitening and orthodontia. This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

Is your dentist on our Dental Blue networks?
Go to [anthem.com](https://www.anthem.com) > Find a Doctor

Enrollment guidelines

To enroll, you must be:

- Under age 65
- A permanent legal resident of your state
- A U.S. resident for at least the last 3 months
- Not eligible for Medicare

Your qualified dependents include:

- Spouse or domestic partner age 65 or younger
- Children (under 25 years of age), or the children (under 25 years of age) of your enrolling spouse or qualified domestic partner (additional children are qualified by law in Indiana. See your Benefit Summary for details).

Medical underwriting requirement

We believe that the cost of our plans should be consistent with your expected health care needs and risk factors. That's why we offer various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge, or
- You may be offered the plan you selected at a higher rate, or
- You may not qualify for the plan listed in this brochure, or
- You may be given information about other options available to you.

If you have a significant medical condition and do not qualify for the plan you've chosen from this brochure or if you have discontinued group coverage, please contact your Anthem Blue Cross and Blue Shield agent or representative for information regarding other Individual coverage options.

Waiting periods

There is a specific twelve-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended by your health care provider or received within twelve months (or six months in Kentucky or Ohio) preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the twelve-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan. Consult with your Anthem Blue Cross and Blue Shield agent or representative if you have a question about the underwriting process.

About our network providers

Notice of provider arrangements: Your network provider's agreement for providing covered services may include financial incentives or risk-sharing relationships based on utilization and quality of services. If you have any questions, please contact Anthem or your provider.

To help you avoid unnecessary out-of-pocket expenses: For some services or supplies (such as prescription drugs), your doctor must receive authorization from Anthem that defines and/or limits the conditions under which the service or supply will be covered. For other services (such as organ transplants), your doctor must certify (and Anthem must approve) that the service is medically necessary and takes place in the appropriate setting. Neither process is a guarantee of coverage.

Using non-network providers: If you receive covered services from a non-network provider, you are responsible for the difference between the actual charge billed and the maximum allowable amount your plan covers plus any deductible, coinsurance, copayments and non-covered charges.

Additional networks available in these states:

In Missouri, the Choice network
In Wisconsin, the POS network

Apply for an Individual Premier health plan today!

To apply

- 1 Complete your Enrollment Application and any other health questionnaires, if applicable.
- 2 Return your completed forms, along with your first month's premium, to your agent.

If your application is approved

Your coverage can start as early as the day after we receive your application (for Kentucky members, coverage can start on the 1st or 15th of month after we receive your application). We will notify you of your effective date in writing.

Sign up for automatic premium payment

Hate writing checks? After your initial payment, our automatic premium payment program will withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of your Enrollment Application.

Get the health coverage your family needs to stay healthy.

Ask your agent about Individual Premier health plans from Anthem Blue Cross and Blue Shield.



anthem.com

This brochure is intended as a brief summary of benefits and services; it is NOT your Contract/Certificate. If there is any difference between this brochure and your Contract/Certificate, the provisions of the Contract/Certificate shall prevail. Benefits and premiums are subject to change.

Life and disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWI collectively underwrite or administer the POS policies. Life and disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.